SECTION 5
ELIGIBILITY RESTRICTIONS

A patient must be eligible for Medicaid on each date a service is provided in order for a provider to receive Medicaid payment for those services. This is also a requirement even when the service has been prior authorized. It is the provider's responsibility to verify a patient's Medicaid eligibility. The following ME (medical eligibility) codes have restricted dental benefits:

09-GR (General Relief): Restricted coverage for patients 21 and over, treatment of trauma and disease, non-periodontal. Benefits for patients under the age of 21 are covered to the same extent they are for all Medicaid eligible patients.

55-QMB (Qualified Medicare Beneficiary): A mandatory coverage group under Medicaid providing payment for qualified individuals of deductible and coinsurance amounts for ***Medicare covered services***.

58 & 59-Presumptive Eligibility (TEMP): Coverage is limited to ambulatory prenatal care services only.

76-Transitional Parents (uninsured): Restricted coverage for treatment of trauma and disease, non-periodontal.

80-Services For Women Following The End Of Pregnancy: Coverage is limited to family planning, and testing and treatment of sexually transmitted diseases (STD's).

Additional information regarding the limitations and restrictions for the above categories of assistance can be found in Sections 1 and 13 of the Medicaid *Provider's Manual* available on the Internet at www.dss.mo.gov/dms.